

- For a waiver, scan and attach this worksheet to the ePCR.
- Paper refusal authorized only when ToughBook unavailable.
- Affix 12-lead and/or ECG strips to back of form.



## EMS Worksheet

Loudoun County Fire & Rescue

PATIENT INFORMATION <small>(Affix Patient ID sticker below if available)</small>					INCIDENT INFORMATION																		
Last Name			M / F		Incident #	2	0	1															
First Name		Age	D.O.B.		Location:																		
Home Street Address					Date:					Unit:													
City		Place Hospital Chart Sticker Here			OIC:																		
State ZIP					Crew:																		
CHIEF COMPLAINT:					Impression:																		
Allergies:					Medications: <span style="float: right;">□ see reverse</span>																		
<input type="checkbox"/> None		<input type="checkbox"/> COPD		<input type="checkbox"/> GU/GI		<input type="checkbox"/> Hypotension		<input type="checkbox"/> Seizures		<input type="checkbox"/> Tuberculosis <input type="checkbox"/> Other:													
<input type="checkbox"/> Asthma		<input type="checkbox"/> Develop Delay		<input type="checkbox"/> High Cholesterol		<input type="checkbox"/> Neuro		<input type="checkbox"/> Stroke/CVA															
<input type="checkbox"/> Cancer: ____		<input type="checkbox"/> Diabetes		<input type="checkbox"/> HIV/AIDS		<input type="checkbox"/> Psych		<input type="checkbox"/> Substance Abuse															
<input type="checkbox"/> Cardiac		<input type="checkbox"/> Endocrine		<input type="checkbox"/> HTN		<input type="checkbox"/> Renal		<input type="checkbox"/> TUIA															
faTime	L.O.C.	Skin Temp Moisture Color		Pupils	Pulse	Resp Rate	Blood Pressure	Pulse Ox	CO2	EKG	Lung Sounds												
	A V P U																						
	A V P U																						
Treatments:		Oxygen	Splinting		IV Therapy		BSG 1	EKG Therapy		Med Therapy													
		<input type="checkbox"/> NRB	<input type="checkbox"/> Backboard/Collar		<input type="checkbox"/> IV			<input type="checkbox"/> 12-Lead															
Stroke Scale		<input type="checkbox"/> Cannula	<input type="checkbox"/> Board Splint		<input type="checkbox"/> IO		BSG 2	<input type="checkbox"/> DEFIB															
		<input type="checkbox"/> CPAP	<input type="checkbox"/> Other:		<input type="checkbox"/> Rate: _____			<input type="checkbox"/> Other:															
<b>Refusal Checklist</b> <small>(Only Select One)</small> <input type="checkbox"/> AGAINST MEDICAL ADVICE  <input type="checkbox"/> REFUSE SPECIFIC CARE  <input type="checkbox"/> REQUEST RELEASE		<b>AMA/Release Checklist</b> <small>(Any "No", Consider Contact Medical Control.)</small> Is the patient (or DDM) oriented to person, place, time, & event? Yes No Is the patient (or DDM) unimpaired by drugs or alcohol? Yes No Is the patient (or DDM) competent to refuse care? Yes No Has patient (or DDM) been advised that 911 can be reactivated? Yes No Have the risks and complications of refusal been discussed? Yes No Is the patient 18 YEARS OF AGE or emancipated? Yes No No medical care or only BLS care rendered? Yes No																					
<b>Waiver of Liability</b> I refuse treatment and/or transportation by the providing ambulance service. I assume responsibility for my own, my child's own, or any family member's medical treatment. I have been advised to seek the attention of a physician. I release the providing ambulance service, its employees, offices and directors from liability resulting from my own, my child's own, or any other family member's refusal of medical treatment or transportation.																							
Signature: _____				Person Signing: <input type="checkbox"/> Patient <input type="checkbox"/> Parent / Guardian <input type="checkbox"/> Other				Patient Left: <input type="checkbox"/> Alone <input type="checkbox"/> With Parent / Guardian: _____ <input type="checkbox"/> With Law Enforcement: _____															
NOTES/OTHER:																							
Technician Signature: _____						EMT- ____		Agency: _____															

MCI Barcode sticker

ALL DATA ON WORKSHEET MUST MATCH  
INFORMATION ENTERED INTO FIELD BRIDGE